Senate

General Assembly

File No. 634

January Session, 2005

Substitute Senate Bill No. 707

Senate, May 3, 2005

The Committee on Finance, Revenue and Bonding reported through SEN. DAILY of the 33rd Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING A NURSING FACILITY USER FEE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective from passage*) (a) As used in this section:

(1) "Commissioner" means the Commissioner of Social Services;

(2) "Federal financial participation matching funds" means all amounts due or paid to the state of Connecticut by the federal government as a result of nursing facility Medicaid payments funded by the user fees described in subsection (b) of this section;

(3) "Medicaid patient day" means a day of care provided to a patient in a nursing facility and billed to the Medicaid program;

(4) "Medicare program" includes fee-for-service Medicare and Medicare managed care;

(5) "Nursing facility" means a chronic and convalescent nursing home or a rest home with nursing supervision licensed by the Department of Public Health;

(6) "Patient day" means a day of care provided to a patient in a nursing facility and billed by the nursing facility, but does not include a patient day billed to the Medicare program or a patient day as used in subparagraph (B) of subdivision (1) of subsection (f) of this section;

(7) "Revenues" means amounts billed by nursing facilities for all room, board and inpatient and outpatient ancillary services, net of contractual allowances and bad debts.

(b) (1) The commissioner shall assess a user fee of approximately fourteen dollars per patient day on each nursing facility, except as otherwise provided in subdivision (1) of subsection (f) of this section.

(2) The commissioner shall impose the user fee assessment in a manner consistent with 42 CFR Part 433, Subpart B, and in no event shall any nursing facility be held harmless within the meaning of 42 CFR 433.68(f).

(3) The amount of the user fee for the fiscal year beginning July 1, 2005, or any part thereof, and for each succeeding fiscal year shall be determined by the commissioner as follows:

(A) The amount calculated pursuant to the provisions of subparagraph (B) of this subdivision minus the total user fees calculated in accordance with the provisions of subparagraph (C) of this subdivision and divided by the anticipated number of state-wide aggregate patient days, excluding patient days attributed to nursing facilities exempted from the user fee assessment pursuant to subdivision (1) of subsection (f) of this section, for the fiscal year ending June 30, 2006, determined on an annualized basis, if necessary, and each succeeding fiscal year, as applicable.

(B) The sum of anticipated state-wide aggregate revenues for all nursing facilities subject to the user fee assessment prescribed by this

section, including revenues from additional per diem payments as provided in subsection (c) of this section, for the fiscal year ending June 30, 2006, as determined on an annualized basis, if necessary, and each succeeding fiscal year, as applicable, multiplied by six per cent.

(C) The user fee imposed on the nursing facilities specified in subparagraph (B) of subdivision (1) of subsection (f) of this section shall be determined in accordance with the requirements of said subparagraph (B), using the anticipated number of applicable patient days for each such nursing facility for the fiscal year ending June 30, 2006, as determined on an annualized basis, if necessary, and for each succeeding fiscal year.

(4) The sum of the state-wide aggregate user fees for each full fiscal year or part thereof shall equal, but shall not exceed, six per cent of state-wide aggregate revenues for all nursing facilities subject to the user fee assessment prescribed by this section for each such fiscal year or on an annualized basis. Not later than sixty days after the end of each fiscal year, the commissioner shall determine actual aggregate state-wide nursing facility revenues for all nursing facilities subject to the user fee assessment prescribed by this section, including revenues from additional per diem payments as provided in subsection (c) of this section, and shall adjust the user fee for that fiscal year as necessary to maintain such six per cent limitation. Not later than sixty days after determining the adjusted user fee, the commissioner shall refund any overpayments to nursing facilities or issue a supplemental user fee bill to nursing facilities.

(5) All amounts collected by the commissioner pursuant to this section and all federal financial participation matching funds, together with any interest and late fees thereon, shall be deposited in the nursing facility security account established pursuant to subsection (e) of this section. No appropriation, expenditure or withdrawal from the nursing facility security account shall be permitted except in accordance with this section.

(c) (1) All amounts in the nursing facility security account

established pursuant to subsection (e) of this section shall be used as follows: The commissioner shall add approximately thirty-five dollars and thirty-four cents to the per diem Medicaid rate established for each nursing facility for the fiscal year beginning July 1, 2005, or upon such later date as the user fee may become effective, and for each succeeding fiscal year. This additional per diem payment shall reimburse nursing facilities for the cost of user fees related to Medicaid patient days and in part for Medicaid payments in prior years that were insufficient to reimburse Medicaid allowable costs due to an inflation index that did not reflect actual cost increases, rate increase limitations set forth in subdivision (4) of subsection (f) of section 17b-340 of the general statutes, and other factors. The per diem Medicaid rate established for each nursing facility for each such fiscal year shall comply with the requirements of subsections (a), (e) and (f) of section 17b-340 of the general statutes and the regulations adopted pursuant to subsection (b) of said section 17b-340, provided no rate limitation set forth in section 17b-340 of the general statutes, shall apply to the additional per diem payment made pursuant to this subsection.

(2) The exact amount of the additional per diem payment made pursuant to subdivision (1) of this subsection shall be determined by the commissioner as follows: The anticipated amount of state-wide aggregate user fees as established by subdivision (3) of subsection (b) of this section to be paid by nursing facilities during the fiscal year beginning July 1, 2005, or any part thereof, on an annualized basis, and each succeeding fiscal year, shall be multiplied by two and divided by the anticipated state-wide aggregate number of Medicaid patient days for the same period. Not later than sixty days after the end of each fiscal year, the commissioner shall determine the actual user fees for that fiscal year as set forth in subdivision (4) of subsection (b) of this section, divided by the actual number of state-wide aggregate Medicaid patient days, and shall adjust the additional per diem payment for that fiscal year as necessary. The commissioner shall make a supplemental payment to nursing facilities or recoup any overpayments not later than sixty days after determining the adjusted per diem payment. In calculating the additional per diem payment, the

commissioner may deduct one-tenth of one per cent from the aggregate state-wide user fees prior to calculating the per diem amount. Such deduction shall be used to fund administrative costs incurred by the Department of Social Services in implementing the requirements of this section.

(3) For the fiscal year beginning July 1, 2006, all federal financial participation matching funds included in the additional per diem payments set forth in subdivision (2) of this subsection that exceed such funds included in such payments for the fiscal year beginning July 1, 2005, as determined on an annualized basis, if necessary, shall be designated to enhance wages, benefits and staffing in nursing facilities.

(d) (1) All user fees paid by nursing facilities shall be an allowable cost for Medicaid rate-setting purposes.

(2) User fees shall be calculated monthly by each nursing facility by multiplying the amount of the user fee times such facility's number of patient days for that month. The user fees shall be payable to the nursing facility security account no later than the last day of the month following the month for which the user fees are calculated.

(3) The commissioner shall prepare forms for nursing facilities to use in reporting and calculating the user fees.

(4) The commissioner may conduct audits of nursing facility user fee payments for the purpose of determining whether the nursing facility has correctly computed the number of patient days, provided no such audit shall review any period of time prior to July 1, 2005, or more than three years prior to the beginning date of such audit.

(5) The commissioner may charge interest on any unpaid user fees at a rate not to exceed the then current rate charged on deficiency assessments pursuant to subsection (b) of section 12-415 of the general statutes.

(e) (1) There is established a nursing facility security account which

shall be a separate nonlapsing account within the General Fund. The account may contain funds deposited pursuant to subdivision (5) of subsection (b) of this section and any other moneys required by law to be deposited in the account. The moneys in said account shall be used by the commissioner to make additional per diem payments to nursing facilities pursuant to subsection (c) of this section. Expenditures from said account shall not be considered general budget expenditures, as defined pursuant to section 2-33a of the general statutes, as amended by this act, for the current fiscal year for the purposes of determining general budget expenditures for the ensuing fiscal year.

(2) The Treasurer shall apply the available resources of the nursing facility security account monthly, beginning with the third month after user fees are first paid into the account, to reimburse the Department of Social Services for the additional per diem payments to nursing facilities pursuant to subsection (c) of this section.

(f) (1) Not later than July 1, 2005, the commissioner shall seek approval from the Centers for Medicare and Medicaid Services for, and shall file a State Medicaid Plan amendment regarding, the user fee and additional per diem payments as set forth in this section. The request for approval shall include a request for a waiver of federal requirements for uniform and broad-based user fees in accordance with 42 CFR 433.68, to (A) exempt from the user fee assessment prescribed by this section any nursing facility owned by an entity that provides continuing care in exchange for a transfer of assets or an entrance fee in addition to or in lieu of periodic payments, regardless of whether such nursing facility participates in the Medicaid program; and (B) impose a user fee in an amount less than the fee determined pursuant to subsection (b) of this section on (i) any nursing facility that bills Medicaid patient days to the Medicaid program of another state when such days constitute twenty-five per cent or more of such facility's total patient days, including Medicare patient days, and (ii) the minimum number of nursing facilities having the highest number of total patient days, including Medicare patient days, as necessary to meet the requirements of 42 CFR 433.68(e)(2).

(2) If the Centers for Medicare and Medicaid Services does not approve a waiver exempting the nursing facilities described in subparagraph (A) of subdivision (1) of this subsection, the commissioner shall withdraw such plan amendment, cease to seek approval for the user fee and additional per diem payments and refrain from imposition or collection of the user fee.

(3) The user fee prescribed by subsection (b) of this section and the additional per diem payment made pursuant to subsection (c) of this section shall be effective retroactively, if necessary, as of the first day of the calendar quarter in which the commissioner files the request for approval and State Medicaid Plan amendment pursuant to subdivision (1) of this subsection. The commissioner shall publish, not later than June 30, 2005, notice of the anticipated rate changes pursuant to this section, as required by 42 USC 1396a(a)(13)(A) and 42 CFR 447.205. The user fee set forth in subsection (b) of this section shall be implemented on the first day of the month following the month in which approval pursuant to subdivision (1) of this subsection is received. The additional per diem payments set forth in subsection (c) of this section shall be made beginning in the first month following the month in which such approval is received.

(g) The commissioner shall publish an annual accounting of deposits into and allocation from the nursing facility security account and the use of such allocations.

(h) Notwithstanding the provisions of this section, collection of the user fee shall terminate upon repeal of the federal law or laws allowing federal matching funds to be paid to the state in connection with expenditures by the state for the additional per diem payment set forth in subsection (c) of this section. Any balance remaining in or due to the nursing facility security account upon such termination shall be paid to nursing facilities on a pro rata basis according to the user fees paid by each such facility.

Sec. 2. Section 2-33a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

The General Assembly shall not authorize an increase in general budget expenditures for any fiscal year above the amount of general budget expenditures authorized for the previous fiscal year by a percentage which exceeds the greater of the percentage increase in personal income or the percentage increase in inflation, unless the Governor declares an emergency or the existence of extraordinary circumstances and at least three-fifths of the members of each house of the General Assembly vote to exceed such limit for the purposes of such emergency or extraordinary circumstances. Any such declaration shall specify the nature of such emergency or circumstances and may provide that such proposed additional expenditures shall not be considered general budget expenditures for the current fiscal year for the purposes of determining general budget expenditures for the ensuing fiscal year and any act of the General Assembly authorizing such expenditures may contain such provision. As used in this section, "increase in personal income" means the average of the annual increase in personal income in the state for each of the preceding five years, according to United States Bureau of Economic Analysis data; "increase in inflation" means the increase in the consumer price index for urban consumers during the preceding twelve-month period, according to United States Bureau of Labor Statistics data; and "general budget expenditures" means expenditures from appropriated funds authorized by public or special act of the General Assembly, provided (1) general budget expenditures shall not include expenditures for payment of the principal of and interest on bonds, notes or other evidences of indebtedness, expenditures pursuant to section 4-30a, payments from the nursing facility security account pursuant to section 1 of this act, or current or increased expenditures for statutory grants to distressed municipalities, provided such grants are in effect on July 1, 1991, and (2) expenditures for the implementation of federal mandates or court orders shall not be considered general budget expenditures for the first fiscal year in which such expenditures are authorized, but shall be considered general budget expenditures for such year for the purposes of determining general budget expenditures for the ensuing fiscal year. As used in this section,

"federal mandates" means those programs or services in which the state must participate, or in which the state participated on July 1, 1991, and in which the state must meet federal entitlement and eligibility criteria in order to receive federal reimbursement, provided expenditures for program or service components which are optional under federal law or regulation shall be considered general budget expenditures.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*July 1, 2005*	2-33a

PH	*Joint Favorable Subst. C/R*	HS
HS	*Joint Favorable C/R*	FIN
FIN	*Joint Favorable*	

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect
Department of Social Services	GF - See Below

Municipal Impact: None

Explanation

This bill assesses a user fee on the revenue generated by nursing facilities based upon patient days and would result in a significant revenue gain for the state. Patient days are defined to include all days paid for either privately or through the Medicaid program on the behalf of clients. The fee is set at 14-dollars per patient day. Medicare patient days are exempted from the user fee. There is also a potential significant cost to the state depending upon how the funds resulting from the user fee are redistributed to nursing homes. The Department of Social Services is required to collect the fee.

Currently there are 248 nursing home facilities with 30, 500 licensed beds providing two levels of care: 1) chronic and convalescent nursing homes (CCNH) ; and 2) rest homes with nursing supervision (RHNS) . There are three sources of revenue for nursing homes: 1) Medicaid; 2) Medicare; and 3) client funds. Client funds generally come from the following sources: the client's estate and assets; long-term care insurance policies; and ongoing retirement benefits such as Social Security payments. Once a client's assets have been exhausted, payments for services will be continued under the state's Medicaid program. In addition, retirement benefits will be "applied" towards the costs of staying in a nursing home (less a personal needs allowance) .

In 2004, there were approximately 10 million patient days generating revenue for nursing homes from all sources of payers. Of this amount, 12 percent of the payments are provided by Medicare, 70 percent are provided by Medicaid and the remaining 18 percent are paid by private sources. The bill assesses a 14-dollar user fee on all patient days except Medicare. This user fee would result in $126.4 million in revenue for the state from an assessment upon 9 million patient days. This revenue gain would be reduced due to potential exemptions of certain nursing facilities. The bill requires the Commissioner of Social Services to request approval from the federal government to waive the fee for certain facilities. The bill does not provide standards for such an exemption; therefore the loss of revenue is indeterminable at this time.

The bill also requires that all amounts collected by the department and all federal matching funds for such amounts are to be deposited in a newly established nursing facility security account. The combined total of the revenue from the fee and the matching revenue from the federal government would be approximately $250 million (which would also be reduced due to potential exemptions of certain nursing facilities). The funds in this account are to be distributed as an approximately $35 per diem rate increase on the established Medicaid nursing rates. Based on the estimated 7 million Medicaid bed days, a total of $245 million would thus be redistributed ot the homes.

There would be additional administrative costs incurred by the Department of Social Services as they would be required to promulgate regulations needed to implement the user fee, assess and collect the fee from nursing homes, and account for the revenue received.

The bill also redefines the spending cap by adding this new account to the items currently considered by statute to be non-capped expenditures for the purposes of calculating the spending cap.

OLR Bill Analysis
sSB 707

AN ACT CONCERNING A NURSING FACILITY USER FEE

SUMMARY:
This bill requires the commissioner of the Department of Social Services (DSS) to impose a nursing facility user fee of approximately $14 a day on most nursing homes in the state. It exempts continuing care retirement communities (CCRC) from the fee, and imposes a lower fee on certain facilities. The fees collected and federal matching Medicaid funds received are to be used to increase by approximately $35 the Medicaid daily rate (add-on) the state pays nursing facilities for serving Medicaid-eligible residents. These additional Medicaid expenditures are exempt from the state's spending cap.

The bill establishes a separate, non-lapsing General Fund account to receive these fees and specifies the uses for the funds.

To carry out the new fee, the bill directs the DSS commissioner to file an amendment to its Medicaid State Plan, and to seek a federal Medicaid waiver to enable her to exempt the CCRCs and charge certain homes less.

EFFECTIVE DATE: Upon passage, except for the spending cap provision, which is effective on July 1, 2005.

NURSING FACILITY USER FEE

Amount of Fee

The bill requires the fee to be approximately $14 per non-Medicare patient day. (A non-Medicare patient day would be a day in which a resident's care is paid for by anything but Medicare.)

To determine the actual fee to be charged, DSS must take the statewide aggregate nursing facility revenues from all facilities subject to the fee, which includes Medicare revenues and the bill's Medicaid-add-ons, and multiply this by 6%. From this product she must subtract any

revenues collected from those facilities that pay a lower fee, as established in the bill. The difference is divided by the FY 06 statewide aggregate patient days, which excludes Medicare patient days and days in which nursing facility care is provided in a CCRC.

For purposes of the fee calculation, the bill requires the revenue and patient day figures to (1) initially apply to FY 06 revenues and patient days, on an annualized basis, if necessary and (2) be calculated in future fiscal years, as applicable.

The bill specifies that the sum of the statewide aggregate user fees for each full fiscal year or part thereof must equal but may not exceed 6% of statewide aggregate revenues from all nursing facilities subject to the fee for each such fiscal year or on an annualized basis.

The bill defines "revenues" as the amounts the nursing facilities bill for all room, board, and inpatient and outpatient ancillary services, net of contractual allowances and bad debts.

The bill requires each nursing facility to calculate user fees it owes each month by multiplying the amount of the fee times the facility's number of non-Medicare patient days that month. The facility must pay the fee into a new General Fund account the bill establishes by the last day of the month following the month for which the fee was calculated. It requires the commissioner to prepare forms for the facilities to use in reporting and calculating the fees.

Adjustments to Fee

The DSS commissioner must determine actual aggregate statewide nursing facility revenues within 60 days after the end of each fiscal year, including the Medicaid add-ons, and must adjust the fee if necessary to maintain the 6% cap. And she must either refund any overpayments or issue supplemental user fee bills within 60 days of making these determinations.

Audits and Late Fees

The bill permits the commissioner to audit user fee payments to determine whether facilities have paid the correct amount, provided the audit does not review any time period before July 1, 2005, or more than three years earlier than the beginning date of the audit.

The bill permits the commissioner to charge interest on any unpaid fees at a rate no higher than the current rate charged on the state sales and use tax deficiency assessments, as established in law.

Nursing Facility Security Account (NFSA) and Uses of Fee

The bill establishes a non-lapsing, nursing facility security account (NFSA) in the General Fund. The account is used to deposit all of the user fees collected, as well as all federal Medicaid matching funds for the add-ons, and interest and late fees. The account may also hold any other money required by law to be deposited into it. No appropriation, expenditure, or withdrawal from the account is allowed unless specified in law.

The bill requires the DSS commissioner to use the money in the account to make additional per diem payments (i.e., add-ons) to nursing facilities in the following manner. She must add approximately $35.34 to each nursing facility's Medicaid daily rate (per patient day of care) for FY 06 (or a later date if the user fee is effective later) and in each succeeding fiscal year. The additional per diem payment must reimburse the facilities for their cost of the fee as it relates to Medicaid patient days. It must also be used to reimburse the facilities for insufficient Medicaid reimbursements in prior years due to (1) an inflation index that did not take into account actual cost increases, (2) rate increase caps specified in law, and (3) "other factors."

The bill further specifies that each nursing facility's Medicaid daily rate must comply with all of the laws and regulations governing rate setting, but the law's overall cap on rate increases does not apply to the bill's additional per diem payment. And it makes the user fee an allowable cost for Medicaid rate setting purposes.

The bill directs the state treasurer to apply the available resources of the NFSA monthly, beginning with the third month after user fees are paid into the account, to reimburse DSS for the add-ons. And it requires the DSS commissioner to publish an annual accounting of deposits into and allocations out of the NFSA, including the use of the allocations.

Calculating the Actual Add-On and Adjustments to It

The commissioner must determine the exact amount of the per diem add-on by multiplying the anticipated statewide aggregate user fees paid during FY 06, on an annualized basis, and in each succeeding fiscal year, by two. This amount must then be divided by the anticipated statewide aggregate number of Medicaid patient days for the same period.

Within 60 days after the end of each fiscal year, the commissioner must determine the actual user fees (presumably those collected), divided by the actual aggregate number of Medicaid patient days and adjust the additional per diem rate accordingly. She must make supplemental payments or recoup overpayments no later than 60 days after adjusting the per diem.

The bill permits the commissioner, when calculating the additional per diem, to deduct 0.1% from the aggregate statewide user fees before calculating the per diem amount to fund the department's costs of administering the fee.

In FY 07, the bill requires all federal matching funds included in the additional per diem payments that exceed those included in the FY 06 per diem add-ons to be designated to enhance nursing facilities' wages, benefits, and staffing. (It is not clear whether this means all nursing facilities or only those subject to the user fee.)

Waiver for Exemptions and Exceptions

The bill directs the DSS commissioner to seek a waiver from, and file a Medicaid state plan amendment with, the federal Centers for Medicare and Medicaid Services (CMS) by July 1, 2005 to carry out the fee and enhanced Medicaid payments. She must specifically request waiver of the federal law's uniformity and broad-based requirements (see BACKGROUND) in order to exempt from the fee any nursing facility owned by an entity that provides continuing care in exchange for a transfer of assets or an entrance fee in addition to or in lieu of periodic payments (i.e., CCRC), regardless of whether these communities participate in the Medicaid program.

The waiver is also needed to impose a lower fee on (1) those facilities that bill another state's Medicaid program for patient days and for which these days constitute at least 25% of the facilities' total patient

days, including days for which Medicare pays for the care and (2) "the minimum number" of facilities having the highest number of total patient days, including Medicare-paid days. This lower-level payment would need to be established in such a way as to conform to the federal uniformity requirements.

If CMS does not approve the waiver, the DSS commissioner must withdraw its state plan amendment and may not proceed with the imposition of the user fee. Likewise, the bill requires collections of the fee to end if any federal law allowing federal matching funds to be paid to the state for the add-ons is repealed. If this occurs, any balance remaining in or due to the NFSA must be returned to the facilities on a pro rata basis according to how much each facility paid.

Effective Date for the Fee and Notification of Rate Changes

The bill requires the user fee to be effective retroactively, if necessary, on the first day of the calendar quarter in which the commissioner files the waiver and state plan amendments.

By June 30, 2005, the DSS commissioner must publish notice of the anticipated Medicaid rate changes, as required by federal law. The fee must be implemented on the first day of the month following the month CMS approves it. DSS must begin paying the Medicaid add-ons during that second month.

EXEMPTION FROM STATE SPENDING CAP

Under the bill, expenditures from the NFSA are not considered general budget expenditures, as defined in the statute governing the state spending cap, for the current fiscal year for the purposes of determining the budget for the ensuing fiscal year.

BACKGROUND

Federal User Fee Law

Federal Medicaid law (42 CFR §433.68) allows states to impose user fees or taxes on health care institutions, including nursing facilities. In general, these fees must be broad-based (they must be imposed on at least all health care items or services in the class or providers of these services) and uniformly (fees are considered uniform when they are the same amount for every provider and they do not hold a particular

facility harmless from paying the fee.) The law limits the amount states can charge to 6% of facility revenues.

States can ask CMS to waive one or both of these requirements and, historically, CMS has approved such requests when the states have been able to show that their fees are generally redistributive.

These fees permit states to enhance payments to health care providers without spending additional state revenues. This is because the fees act as the state match to the federal Medicaid matching funds, with the collected fee in essence becoming the state expenditure that is eligible for the federal match.

Nursing Facility Rate Setting

State statutes contain a complex cost-based formula with various caps on different costs for determining Medicaid payments to nursing homes, but the legislature for a number of years has limited potential increases in nursing homes' reimbursements to a specified percentage of prior-year reimbursements, regardless of actual allowable costs reported.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute Change of Reference
Yea 19 Nay 4

Human Services Committee

Joint Favorable Change of Reference
Yea 15 Nay 1

Finance, Revenue and Bonding Committee

Joint Favorable Report
Yea 36 Nay 11